Ex. G

LEGALPARTNERS LP
13915 N MOPAC EXPY, STE 303
AUSTIN, TX 78728-6517
TEL: 512/440-8187 FAX: 512/440-8780

AARON BROTHERS, AS HOLDER OF POWER OF ATTORNEY FOR AND AS NEXT FRIEND FOR WILLIAM SLADE SULLIVAN
V.
THE CITY OF ROUND ROCK, TEXAS, OFFICERS N.J. ZOSS, K.A. MAYO, AND A.P. BALLEW; AND RICK'S CABARET INTERNATIONAL, INC., A/K/A RCI DINING

RECORDS REGARDING: WILLIAM SLADE SULLIVAN

RECORD TYPE: MEDICAL RECORDS

RECORDS FROM: ST. DAVID'S ROUND ROCK MEDICAL CENTER
HEALTHPORT
6000 Northwest Parkway, Suite 124
San Antonio, Texas 78249

DELIVER TO: Susan Balagia
Wright & Greenhill
221 West 6th Street, Suite 1800
Austin, Texas 78701

/CLIENT FACE/AD/SB 197974

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

AARON BROTHERS, AS HOLDER OF POWER OF ATTORNEY FOR AND AS NEXT FRIEND FOR WILLIAM SLADE SULLIVAN

VS.

CIVIL ACTION NO. 1:14-CV-349 LY

THE CITY OF ROUND ROCK, TEXAS, OFFICERS N.J. ZOSS, K.A. MAYO, AND A.P. BALLEW; AND RICK'S CABARET INTERNATIONAL, INC., A/K/A RCI DINING SERVICES (ROUND ROCK), INC., A/K/A RCI HOSPITALITY HOLDINGS, INC,

DEPOSITION BY WRITTEN QUESTIONS PROPOUNDED TO THE WITNESS, CUSTODIAN OF RECORDS FOR:

ST. DAVID'S ROUND ROCK MEDICAL CENTER
HEALTHPORT
6000 Northwest Parkway, Suite 124
San Antonio, Texas 78249
(210) 581-4585

1. Please state your full name, occupation, and official title.

ANSWER: Margie Tiedt HIM Director

2. Have you received the attached subpoena duces tecum for the production for all the records and other documents pertaining to WILLIAM SLADE SULLIVAN?

ANSWER: Yes.

3. Do you understand the subpoena requests all the records and documents pertaining to WILLIAM SLADE SULLIVAN, and is not limited to records and documents related to the injury or illness which forms the basis for this lawsuit nor is it limited in scope or as to the type of record or document?

ANSWER: Yes.

4. Has WILLIAM SLADE SULLIVAN been treated or examined by ST. DAVID'S ROUND ROCK MEDICAL CENTER?

ANSWER: Yes.

5. Has **ST. DAVID'S ROUND ROCK MEDICAL CENTER** made or caused to be made any memorandum, report, record, or data compilation, in any form, of the examination and/or treatment of said patient?

ANSWER: Yes.

6. Are these memoranda, reports, records, or data compilations, under your care, supervision, direction, custody and/or control?

ANSWER: Yes.

7. Were these memoranda, reports, records, or data compilation, made or caused to be made by **ST. DAVID'S ROUND ROCK MEDICAL CENTER?**

ANSWER: Yes.

8. Please state whether or not it was the regular course of business of **ST. DAVID'S ROUND ROCK MEDICAL CENTER** for a person with knowledge of the acts, events, conditions, opinions, or diagnoses, recorded to make the record or to transmit information thereof to be included in such record.

ANSWER: Yes.

9. Were the entries of these memoranda, reports, records, or data compilations, made at or shortly after the time of the transaction recorded on these entries?

ANSWER: Yes.

10. Were these records kept in the normal course of business?

ANSWER: Yes.

11. Please hand exact duplicates of the medical records pertaining to **WILLIAM SLADE SULLIVAN** or the originals thereof for photocopying to the notary public taking your deposition for attachment to this deposition. Have you done as requested. If not, why not?

ANSWER: Yes.

12. Please hand exact duplicates of all other documents pertaining to **WILLIAM SLADE SULLIVAN** or the originals thereof for attachment to this deposition (this should include but is not limited to any and all records, files, papers, billing and payment records, medical charts, notes, nurses' notes, logs, x-ray films and/or reports, insurance records, correspondence to or from any persons, and any other tangible documents or recorded information pertaining to **WILLIAM SLADE SULLIVAN.** Have you now provided all the records and documents pertaining to **WILLIAM SLADE SULLIVAN?** If not, identify for the notary public the records and documents you did not produce and explain why you did not produce them.

ANSWER: Yes.

13. Please identify and describe any narrative that was created at the request of the patient or the patient's attorney.

ANSWER: None.

14. Please identify each medical expense or other expenses which **WILLIAM SLADE SULLIVAN** incurred as a result of health care treatment provided by you, stating the amount, the date each such expense was incurred, whether the expense is outstanding (unpaid), the amount of payment made on each such expense and the person or entity making such payment.

ANSWER: Custodian of medical records only.

15. Are you aware of any other hospital, clinic, sanitarium, physician, chiropractor, or osteopath, that may have possession of records pertaining to the person who is the subject of this deposition? If so, please state the name and address of such entity and describe briefly what records they may possess.

ANSWER: No.

16. Have you been requested, directed or has it even been suggested by any person (whether doctor, lawyer, patient or anyone else) that any part of the records subject of this deposition be withheld or protected from discovery for any reason? If so, please state the name and address of the person who conveyed this information to you and when such event occurred.

ANSWER: No.

17. Do you know whether or not, or do you have any reason to believe that the records subject of this deposition have in any manner been edited, purged, culled or in any other manner made different from the way such records existed when created? If so, please explain your knowledge or belief in this regard.

ANSWER: No.

18. As custodian of records for **ST. DAVID'S ROUND ROCK MEDICAL CENTER**, do you personally have any medical education, background, or expertise in the diagnosis of medical conditions?

ANSWER: No.

19. As custodian of records for **ST. DAVID'S ROUND ROCK MEDICAL CENTER**, do you personally have any medical expertise whatsoever in determining what types of treatment or medical services are or are not called for by any given medical condition?

ANSWER: No.

20. As custodian of records for **ST. DAVID'S ROUND ROCK MEDICAL CENTER**, do you personally have any medical education, background, or experience which would enable you to diagnose the medical condition of **WILLIAM SLADE SULLIVAN**?

ANSWER: No.

21. As custodian of records for **ST. DAVID'S ROUND ROCK MEDICAL CENTER**, do you have any medical expertise whatsoever which would enable you to determine what type of treatment or medical services were or were not called for with respect to the medical condition of **WILLIAM SLADE SULLIVAN**?

ANSWER: No.

22. In light of your responses to the preceding four questions, do you consider yourself able to provide sworn testimony as to what treatments or medical services were or were not necessary to treat the effects of the injuries of **WILLIAM SLADE SULLIVAN?**

ANSWER: Yes

Margie Novak RHIA
WITNESS, CUSTODIAN OF RECORDS

Before me, the undersigned authority, on this day personally appeared Margie Novak, custodian of records for **WILLIAM SLADE SULLIVAN**, known to me to be the person whose name is subscribed to the foregoing instrument in the capacity therein stated, who being first duly sworn, stated upon his/her oath that the answers to the foregoing questions are true and correct. I further certify that the records attached hereto are exact duplicates of the original records.

SWORN TO AND SUBSCRIBED before me, this 17 day of October, 2014.

Notary Public in and for The State of Texas

JOHN PHILLIP CEDILLO
NOTARY PUBLIC
STATE OF TEXAS
MY COMM. EXP. 09/27/2016

normal, cooperative
Head/Eyes: atraumatic, normocephalic, EOMI, clear cornea, normal conjunctiva/sclera, NL eyelids/periorbital
ENT: atraumatic, moist mucous membranes, normal pharynx, normal ears, normal sinus, normal nose, normal dentition
Neck: supple/no meningismus, non-tender, full range of motion, no JVD
Respiratory/Chest: atraumatic, no distress, no tenderness, no wheezes, no rales, no rhonchi
Cardiovascular: regular rate and rhythm, normal heart sounds, normal capillary refill, no pedal edema
Abdomen: soft, non-tender, no guarding/rebound, no distention
Back: normal inspection, no midline vertebral tend, no muscle spasm, no CVA tenderness, muscle tenderness (subjective bilateral lumbar)
Skin: normal color, warm, dry, normal turgor, abrasion (left knee)
Neurologic: ========== (intoxicated - uncooperative), moves all extremeties to pain.

Results/Interpretations

Results:
Laboratory Tests

03/21/14 0604:

Laboratory Tests:

	03/21 0611	03/21 0604	03/21 0446
Chemistry			
POC Sodium (135 - 143 mmol/L)	140		
POC Potassium (3.5 - 5.1 mmol/L)	3.7		
POC Chloride (98 - 110 mmol/L)	104		
POC Total CO2 (18 - 30 mmol/L)	26		
POC BUN (5 - 20 mg/dL)	13		
POC Creatinine (0.6 - 1.3 mg/dL)	1.5 H		
Est GFR (African Amer) (>60)	> 60		
Est GFR (Non-Af Amer) (>60)	54 L		
POC Glucose (70 - 110 mg/dL)	159 H		
POC Ioniz Calcium Meas (1.07 - 1.31 mmol/L)	1.08		
Hematology			
WBC (4.0 - 11.0 K/mm3)		12.8 H	

RBC (4.10 - 5.70 M/mm3)		4.62	
Hgb (13.0 - 17.0 g/dL)		14.4	
Hct (37.0 - 49.0 %)		42.5	
MCV (80.0 - 100.0 fL)		92.0	
MCH (27.0 - 34.0 pg)		31.1	
MCHC (32.0 - 36.0 g/dL)		33.6	
RDW (11.0 - 15.0 %)		14.6	
Plt Count (130 - 400 K/mm3)		293	
MPV (6.8 - 10.0 fL)		7.6	
Neutrophils % (34 - 62 %)		83.2 H	
Lymphocytes % (20 - 53 %)		8.2 L	
Monocytes % (1.7 - 9.1 %)		7.3	
Eosinophils % (0.0 - 10.0 %)		0.3	
Basophils % (0.0 - 3.0 %)		0.5	
Neutrophils # (2.2 - 4.8 K/mm3)		10.6 H	
Lymphocytes # (1.5 - 4.0 K/mm3)		1.1 L	
Monocytes # (0 - 1.0 K/mm3)		1.0	
Eosinophils # (0 - 0.7 K/mm3)		0.0	
Basophils # (0 - 0.2 K/mm3)		0.1	
Toxicology			
Ethyl Alcohol (0 - 15 mg/dL)			223 H

Lab result interpretations: Labs reviewed, WBC elevated
Head CT interpretation:
Interpreted by radiologist: Yes
Discussed with radiologist: Yes
Reviewed by: ED physician
With contrast: No
General: no acute disease
CT General
Interpreted by radiologist: Yes (CTA Head/Neck)
Discussed with radiologist: Yes
Reviewed by: ED physician
With contrast: Yes
Findings:
normal CTA head/neck, severe spinal stenosis in cervical spine.

MDM-Back Pain over 40

ED Course
Patient course: stable, 0525am: Pt now states unable to move left side of his body states it has been that way since got into his truck at bar around 10pm. Sent for CVA work up.

Round Rock Medical Center
2400 Round Rock Ave * Round Rock, Texas 78681

PATIENT:	SULLIVAN,WILLIAM SLADE	MED REC#:	D000476332
ACCOUNT#:	[redacted]	ROOM #:	D.TELOF
DATE OF BIRTH:	01/14/70	LOCATION:	D.ERIP
SEX:	M	PT STATUS:	ADM IN
ATTENDING PHYS:	BUTB	ADM DATE:	03/23/14
REPORT TYPE:	HISTORY AND PHYSICAL	DIS DATE:	

CHIEF COMPLAINT:
Alcohol intoxication.

HISTORY OF PRESENT ILLNESS:
This is a 44-year-old male who came in to the Emergency Department with alcohol intoxication. The story is that he was at a bar in Gentleman's Club last night where he was found to be passed out by police in his car. They reportedly yanked him out of the car and drug him on the ground. He says after that point, he developed severe pain in his lower back as well as left arm and left leg weakness and paralysis. History has been very difficult to obtain from this patient due to him being intoxicated with alcohol. The patient is occasionally belligerent, yelling at us, refusing to answer questions. Since he has been in the Emergency Department, he now reports that he cannot move his right leg. Initially, the nurse said that he was able to move his right leg and had sensation there, but now he reports that he can only move and has sensation in his right upper extremity. He denies any specific bowel or bladder problems, no constipation or difficulty urinating and no loss of bowel or bladder. His main complaint now is that he has severe lower back pain. He does suffer from chronic back pain throughout his whole back, not in any specific location. He additionally reports that he has been having shortness of breath for the last 6 months. This has been followed by his primary doctor. He is not sure what tests have been done for this, but he does take nebulizer treatments he says as needed for breathing difficulty. He denies any previous history of numbness, tingling in arms or legs. Denies vision deficit. Denies speech deficit. He does say he has no sensation in any area where he also has weakness. He also in the ER has intermittently been refusing neurological examination and reassessments. He is refusing tests and then later will agree to testing. He also required sedation with Etomidate ordered by the ED physician in order to undergo CT imaging of the head.

PAST MEDICAL HISTORY:
Includes hypothyroidism, as well as chronic back pain from spinal stenosis, reactive airway disease and morbid obesity.

ALLERGIES:
PENICILLIN, HEPARIN, CHICKEN, and CITRUS.

OUTPATIENT MEDICATIONS:
Levothyroxine and nebulizer.

SOCIAL HISTORY:

He denies smoking. He drinks alcohol, last drink was last night.

PAST SURGICAL HISTORY:
Includes thyroidectomy, previous back surgery.

FAMILY HISTORY:
Noncontributory.

REVIEW OF SYSTEMS:
A 10 point review of systems was attempted and is negative per HPI, although the patient was not cooperative answering all questions.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 98.2, pulse 86, respirations 18, initial blood pressure 115/70, and pulse ox 96%.
GENERAL: He is alert, oriented, occasionally combative but is oriented x3.
HEENT: Normocephalic, atraumatic. Pupils are equal, round and reactive to light. Oropharynx is clear.
NECK: Supple, no lymphadenopathy.
CARDIOVASCULAR: Regular, without murmur.
LUNGS: Had no wheezes were clear.
ABDOMEN: Obese, soft, no tenderness to palpation.
EXTREMITIES: Had 1+ bilateral lower extremity edema.
NEUROLOGIC: Currently, he has normal strength and sensation in his right upper extremity only. He reports 0/5 strength and he will not attempt to move any of his other extremities. He additionally reports decreased sensation on his left arm and bilateral lower extremities. Reflexes were difficult to elicit due to his body habitus, but I could not obtain patellar reflexes. There is perhaps some slight 1+ ankle reflexes bilaterally. Again this is very difficult to elicit due to the patient's body habitus. He did not withdraw to pain in his lower extremities or left upper extremity.

LABORATORY DATA:
CBC was significant for white blood cell count of 12.8, INR is 0.99. Troponin was 0. BMP was significant for glucose of 159, creatinine 1.5. Alcohol level was 223. Initial CT angiogram of the head showed no acute process.

IMPRESSION AND PLAN:
1. Left-sided weakness with progression to bilateral lower extremity weakness and left upper extremity weakness. This is concerning given the progressive nature. The etiology is concerning for possible spinal cord compression. The initial assessment was concerning for possible CVA given only left-sided weakness. Now with progression to right leg weakness, spinal cord compression is concerning in this patient with a previous history of spinal stenosis. Neurology with Dr. Boske has evaluated this patient and is recommending starting the patient on IV Decadron. We have ordered an MRI of the brain. Neurology also was recommending MRI of the entire spine; however, the patient is refusing these tests unless he is completely sedated. Unfortunately, his blood pressure has declined at 80/50 and we do not have conscious sedation here in our Emergency Department so we discussed with him that it is not possible to safely sedate him currently for MRI due to these issues and concern for progressive neurological exam that might require intervention. Over sedation would further limit our ability to perform neurological examination. Our neurologist is recommending urgent transfer to St. David's

main for ongoing neurological assessment and potential neurosurgery evaluation. The patient may ultimately require conscious sedation for MRI testing once stabilized. It is difficult to fully assess this patient as he again is refusing neurological testing intermittently and refusing MRI at this time. Part of this is likely related to his alcohol intoxication, causing him to refuse some of these testing. We do recommend neurology continue to follow this patient closely due to his concerning symptoms and that MRI be obtained when it is able to be safely obtained. For now the patient will be continued on decadron and will await the ability to perform further tests. CT of the spine was also ordered by neurology, but again the patient refused this examination.
2. Hypotension - The patient became acutely hypotensive in the ED. This was asymptomatic. Will give IV fluid bolus and monitor. Will check his TSH.
3. Acute kidney injury versus chronic kidney disease, I will give IV fluids and monitor.
4. Alcohol intoxication. We will provide IV fluids and allow the patient to sober up.
5. Chronic back pain. We will follow up MRI reports once able to be completed.
5. Hypothyroidism. The patient does not know his dose of outpatient medication. I will check a TSH.
6. Deep venous thrombosis prophylaxis. I will hold off on Lovenox at this point due to the potential for possible spinal cord injury and surgical intervention being required.

Brian R Butler, MD

DDT:03/21/2014 1120
TDT:03/21/2014 1154
Trans By: VN/NTS_MSS
Job #1454752

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Authenticated and Edited by Brian R Butler MD On 3/21/14 1:19:19 PM

Report #: 0321-0083

Electronically Signed by Brian Butler on 03/21/14 at 1319

PATIENT: SULLIVAN,WILLIAM SLADE ACCOUNT #: [redacted]

Round Rock Medical Center
2400 Round Rock Ave * Round Rock, Texas 78681

PATIENT:	SULLIVAN,WILLIAM SLADE	MED REC#:	D0000476332
ACCOUNT#:	[redacted]	ROOM #:	D.TELOF
DATE OF BIRTH:	01/14/70	LOCATION:	D.ERIP
SEX:	M	PT STATUS:	ADM IN
ATTENDING PHYS:	BUTB	ADM DATE:	03/23/14
REPORT TYPE:	CONSULTATION	DIS DATE:	

DATE OF CONSULTATION: 03/23/2014

TYPE OF CONSULTATION: Neurology

REFERRING PHYSICIAN:
Dr. McCorkle.

CHIEF COMPLAINT:
Left-sided weakness, progressing to bilateral lower extremity weakness.

HISTORY OF PRESENT ILLNESS:
Mr. Sullivan is an agitated 44-year-old male with history of ankylosing spondylitis, multiple previous back surgeries, thyroid storm, CHF and chronic back pain who presents with acute onset left-sided weakness transitioning to bilateral lower extremity weakness. History obtained per chart review, discussion with treating physicians/ER physician and discussion with his mother as patient is currently intoxicated and agitated. Reportedly late last night, the patient was found outside Rick's Cabaret in his car. Police were called due to concern for drinking and driving. The patient refused to get out of his vehicles so police forcibly removed him. The patient sustained an abrasion on his left knee and complained of worsening back pain. Police called EMS and brought the patient to the ER. Per initial ER note, the patient moved all 4 extremities to pain, but was intoxicated and not participating in detailed exam. Over course of stay, he complained of left arm and leg paralysis and numbness which then transitioned to his bilateral lower extremities (left upper and lower extremity and right lower extremity). Per ER note, he then told ER physician he felt weak while in his car. He has full movement of his right upper extremity. He reports current neck and back pain greater than baseline. He is unsure what makes symptoms better or worse, or if this happened before. Again, he is intoxicated and noncooperative.

REVIEW OF SYSTEMS:
Unable to obtain due to patient's mental status.

PAST MEDICAL HISTORY, per discussion with his mother: His medical history is likely incomplete and I have requested a copy of his medical records from his PCP.
1. Ankylosing spondylitis.
2. Multiple "back surgeries."
3. History of thyroid storm treated at Georgetown.
4. Congestive heart failure.

HOME MEDICATIONS:

Unknown.

SOCIAL HISTORY:
He uses alcohol. His mother is concerned that he may also be using pain medication inappropriately and possible other drugs, but she is not sure.

FAMILY HISTORY:
Unable to obtain due to the patient's mental status.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 98.2, pulse 81, blood pressure 78/47, respiratory rate 18, pulse ox 100%.
GENERAL: Agitated male due to intoxication, lying in bed, oriented x1, alert.
HEENT: EOMI, PERRL, 3 beats of end-gaze nystagmus horizontally left and right.
RESPIRATORY: Clear to auscultation bilaterally. No wheezes, rhonchi or crackles.
CARDIOVASCULAR: Regular rate and rhythm, no murmurs, rubs or gallops.
ABDOMEN: Obese, soft, nontender, nondistended.
MENTAL STATUS: Agitated, unable to assess memory, attention span and/or fund of knowledge given intoxication. Speech is spontaneous and fluent, no slurring. He follows commands.
CRANIAL NERVES: Refer to HEENT. Visual fields full to confrontation. Unable to assess facial sensation, uvula, SCM/trapezius strength or tongue protrusion due to lack of patient cooperation. He has no gross facial asymmetry. Auditory acuity is grossly intact.
MOTOR: Right upper extremity 4-5/5 strength; 0/5 bilateral lower extremities and left upper extremity with positive Hoover's sign. He is not giving any effort, but is very rigid in his lower extremities.
SENSATION: No response to strong pain applied to his lower extremities. He does feel pain in his right upper extremity.
COORDINATION: Does not cooperate with exam.
REFLEXES: Areflexic patellar, hyporeflexic achilles, biceps, triceps, brachioradialis; bilateral plantar flexion.
GAIT: Deferred due to weakness/fall risk.

LABORATORY DATA:
1. BMP: Na 140, K 3.7, Cl 104, CO2 1.08, GLUC 159, CO2 26, BUN 13, CR 1.5.
2. CBC: WBC 12.8, HEB 14.4, HCT 42.5, PLT 298.
3. Blood alcohol level 3/23/14 at 4:46 a.m. 223.

IMAGING:
1. CT head: I personally reviewed, which showed no evidence of mass, bleed or other abnormality. Formal radiology report pending.
2. CTA head and neck per discussion with the ER physician who spoke with radiologist. Study showed severe spinal stenosis in the cervical spine, but otherwise no other abnormality.

ASSESSMENT AND PLAN:
1. Acute left-sided weakness/bilateral lower extremity weakness: The patient is intoxicated and does not participate with physical exam (positive Hoover sign). Therefore, unable to make an accurate assessment/diagnoses. Additionally, he was refusing any assessments by nursing and is refusing any

PATIENT: SULLIVAN,WILLIAM SLADE ACCOUNT #: [redacted]

and all imaging at this time (likely due to acute intoxication). Weakness may be due to encephalopathy/intoxication; however, he is at higher risk for spinal cord compression given history of ankylosing spondylosis, "severe cervical stenosis" seen on CTA and possible recent trauma given his lack of

cooperation with the police tonight.
--Therefore, will treat with Decadron, as if he does have a spinal cord compression given permanent disability associated with such a process.
--I explained to patient the gravity of this situation and that he needed to imaging and he said he did not care. He became agitated and angry.
--I highly advocate for transfer to higher level of care (St. David's Main) given there is no neurology available over the weekend and also for possible neurosurgical intervention if required.
--I have requested his medical chart from his primary care physician to obtain further medical history.
--I have also requested UDS.
--Would also recommend MRI of the brain given his alcohol use and unclear if he also has any other drug which could have precipitated a stroke.
--I have been updated patient's nurse and hospitalist on current plan of care and I have obtained further history per discussion with his mother.

2. Alcohol abuse: Recommend counseling alcohol cessation once patient is no longer intoxicated. Recommend withdraw checks. Would not start scheduled benzos at this time given he is hypotensive and he is still currently intoxicated; however, treat with benzos p.r.n. for any withdrawal symptoms.

3. History of thyroid storm: Recommend checking TSH, although he does not have any current signs or symptoms.

4. Congestive heart failure: Will defer to internal medicine.

Critical care performed: 40 minutes. Time includes direct patient care, patient assessment, coordination of care, interpretation of data, review of medical records and family consultation regarding history, and documentation of the patient's care.

Alexandra C Boske, MD

DDT:03/21/2014 1201
TDT:03/21/2014 1331
Trans By: SI/TIS
Job #: 1454800

Copies To:
Authenticated and Edited by Alexandra C Boske, MD On 3/21/14 4:53:22 PM

Report #: 0321 0104

Electronically Signed by Alexandra Boske MD on 03/21/14 at 1653

PATIENT: SULLIVAN,WILLIAM SLADE ACCOUNT #: [redacted]